TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Health System

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-0267-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable per ASC Rule 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $169.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, the bill was sent for reconsideration. It was determined that no additional payment is owed to the provider."

Response Submitted by: ESIS, P.O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2015	72070	$169.48	$107.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403 (d), which requires that, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

2. 28 Texas Administrative Code 134.403 (f) states,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   Reimbursement for the services in dispute will be calculated as follows;

   - Procedure code 72070 has a status indicator of Q1, which denotes STVX-packaged code. Per CMS Medicare Claims Processing Manual, www.cms.hhs.gov , Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), 10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same Date of Service,

     Where a claim contains multiple codes that are STVX-packaged codes and does not contain a procedure with status indicator S, T, V or X on the same date of service, separate payment is made for the STVX-packaged code that is assigned to the highest paid APC and payment for the other STVX-packaged codes on the claim is packaged into the payment for the highest paid STVX-packaged code.

     This service is classified under APC 0261, which, per OPPS Addendum A, has a payment rate of $95.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.01. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $46.73. The non-labor related portion is 40% of the APC rate or $38.01. The sum of the labor and non-labor related amounts is $84.74. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $84.74. This amount multiplied by 200% yields a MAR of $169.48.
   - Procedure code 72100 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

3. The total allowable reimbursement for the services in dispute is $169.48. This amount less the amount previously paid by the insurance carrier of $61.95 leaves an amount due to the requestor of $107.53. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $107.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $107.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.